

		FOR OHF USE					

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2003  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2003)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035386

Facility Name: Milestone-Sun Valley

Address: 3351 Sun Valley Terrace 3351 Sun Valley Terrace Rockford Rockford 61103 61103  
Number City Zip Code

County: Winnebago

Telephone Number: (815) 654-6616 (815) 654-6616  
Fax #

IDPA ID Number: 362769801004

Date of Initial License for Current Owners: 06/12/1989

Type of Ownership:

X

VOLUNTARY, NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code 501 (c) 3

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:  
Name: Hugh Lippitt Telephone Number: (815) 654-6100 Ext. 2806

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the  
State of Illinois, for the period from 07/01/2002 to 06/30/2003  
and certify to the best of my knowledge and belief that the said contents  
are true, accurate and complete statements in accordance with  
applicable instructions. Declaration of preparer (other than provider)  
is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information  
in this cost report may be punishable by fine and/or imprisonment.

Officer or  
Administrator  
of Provider

(Signed) \_\_\_\_\_  
(Type or Print Name) Hugh W. Lippitt  
(Title) Vice President, Finance

Paid  
Preparer

(Signed) \_\_\_\_\_  
(Print Name and Title) \_\_\_\_\_  
(Firm Name & Address) \_\_\_\_\_  
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE  
ILLINOIS DEPARTMENT OF PUBLIC AID  
201 S. Grand Avenue East  
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Milestone-Sun Valley

# 0035386 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	8	ICF/DD 16 or Less	8	2,920	6
7	8	TOTALS	8	2,920	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	2,698			2,698	13
14	TOTALS	2,698			2,698	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.40%

D. How many bed-hold days during this year were paid by Public Aid? 86 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO X

I. On what date did you start providing long term care at this location? Date started 06/12/89

J. Was the facility purchased or leased after January 1, 1978? YES X Date 06/12/89 NO

K. Was the facility certified for Medicare during the reporting year? YES NO X If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL X MODIFIED CASH\* CASH\*

Is your fiscal year identical to your tax year? YES X NO

Tax Year: 06/30/03 Fiscal Year: 06/30/03 \* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Milestone-Sun Valley # 0035386 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary		1,289	375	1,664		1,664		1,664		1
2	Food Purchase		23,559		23,559		23,559		23,559		2
3	Housekeeping		5,399	554	5,953		5,953		5,953		3
4	Laundry										4
5	Heat and Other Utilities			9,046	9,046		9,046		9,046		5
6	Maintenance	8,439	5,731	2,317	16,487		16,487		16,487		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	8,439	35,978	12,292	56,709		56,709		56,709		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	168,896	227	1,168	170,291		170,291		170,291		10
10a	Therapy										10a
11	Activities		2,356		2,356		2,356		2,356		11
12	Social Services	7,104			7,104		7,104		7,104		12
13	Nurse Aide Training										13
14	Program Transportation		2,006	3,139	5,145		5,145		5,145		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	176,000	4,589	4,307	184,896		184,896		184,896		16
	<b>C. General Administration</b>										
17	Administrative	5,044		6,304	11,348	(3,156)	8,192		8,192		17
18	Directors Fees										18
19	Professional Services			648	648		648		648		19
20	Dues, Fees, Subscriptions & Promotions			425	425		425		425		20
21	Clerical & General Office Expenses	6,784	3,045	2,108	11,937	3,156	15,093		15,093		21
22	Employee Benefits & Payroll Taxes			39,702	39,702		39,702		39,702		22
23	Inservice Training & Education										23
24	Travel and Seminar			263	263		263		263		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			3,043	3,043		3,043		3,043		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	11,828	3,045	52,493	67,366		67,366		67,366		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	196,267	43,612	69,092	308,971		308,971		308,971		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			11,747	11,747	611	12,358		12,358			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,019	15,019		15,019		15,019			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			425	425	(425)						35
36	Other (specify):* Alloc.Maint. Blding.			186	186	(186)						36
37	TOTAL Ownership			27,377	27,377		27,377		27,377			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			26,032	26,032		26,032		26,032			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			26,032	26,032		26,032		26,032			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	196,267	43,612	122,501	362,380		362,380		362,380			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
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29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## Summary A

**06/30/2003**

[illegible]

## Summary B

**06/30/2003**

[illegible]



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Pages 24 & 25		See Pages 24 & 25				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		See Page 27	\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION



IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Illinois Health Facilities		X	Mortgage	N/A	06/25/97	\$ 200,000	\$ 194,924	08/15/22	7.3750	\$ 14,770	1	
2				See Addendum B								2	
3												3	
4												4	
5												5	
	Working Capital												
6	Amcore Bank N.A. Rockford		X	Line of Credit	N/A	5/10/02	5,000,000		1/10/04	4.2500	249	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 5,200,000	\$ 194,924			\$ 15,019	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 5,200,000	\$ 194,924			\$ 15,019	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1998	8		
	1999	9		
	2000	10		
	2001	11		
	2002	12		
			FOR OHF USE ONLY	
			13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Milestone-Sun Valley COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0035386

CONTACT PERSON REGARDING THIS REPORT Hugh W. Lippitt

TELEPHONE (815) 639-2806 FAX #: (815) 654-6444

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A. Square Feet: 6,400

B. General Construction Type: Exterior Brick/Cedar Frame Wood Number of Stories one

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Project	33,000		\$ 32,954	1
2					2
3	TOTALS	33,000		\$ 32,954	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	8		1989	1989	\$314,472	\$10,482	30	\$10,482	\$	\$147,622	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Smoke Detectors		1997		3,050	203	15	203		1,186	9
10	Carpet		1998		3,290	329	5	329		3,290	10
11	Vertical Blinds		1998		803	107	5	107		803	11
12	Maintenance Building		1985		N/A	186	25	186		N/A	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
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62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$321,615	\$11,307		\$11,307	\$	\$152,901	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 6,256	\$ 626	\$ 626		10 yrs	\$ 2,884	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	21,965				7-10 yrs	21,965	73
74	Allocated Computer System		425	425		10 yrs		74
75	TOTALS	\$ 28,221	\$ 1,051	\$ 1,051			\$ 24,849	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Client Care	1993 Ford Van	1992	\$ 14,193	\$	\$		3 yrs	\$ 14,193	76
77	Client Care	1998 Ford Van	1997	22,969				3 yrs	22,969	77
78										78
79										79
80	TOTALS			\$ 37,162	\$	\$			\$ 37,162	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 419,952	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,358	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 12,358	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 214,912	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease.
- 

9. Option to Buy:
- ☐ YES☐ NO
- Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?  
16. Rental Amount for movable equipment: \$ Description:
- ☐ YES☐ NO
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	\$
13.	/2005	\$
14.	/2006	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Milestone-Sun Valley# 0035386Report Period Beginning: 07/01/2002Ending: 06/30/2003

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2003

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 450	\$ 2,253,377	1
2	Cash-Patient Deposits	1,894	130,370	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	64,026	3,269,211	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance		77,658	6
7	Other Prepaid Expenses		31,361	7
8	Accounts Receivable (owners or related parties)	121,402		8
9	Other(specify): <u>A/R Other</u>		15,801	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 187,772	\$ 5,777,778	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,954	1,310,201	13
14	Buildings, at Historical Cost	321,615	15,194,468	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	65,383	4,860,962	16
17	Accumulated Depreciation (book methods)	(214,911)	(10,531,208)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	4,788	121,401	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(4,788)	(116,692)	20
21	Restricted Funds		673,550	21
22	Other Long-Term Assets (specify) <u>Escrow &amp; Loan Fees</u>		681,484	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 205,041	\$ 12,194,166	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 392,813	\$ 17,971,944	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	\$ 1,648,023	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,894	130,370	28
29	Short-Term Notes Payable		167,989	29
30	Accrued Salaries Payable		492,670	30
31	Accrued Taxes Payable (excluding real estate taxes)		176,709	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		110,763	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Pension, Wrkmns Comp, Sec Dep, etc</u>		654,713	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,894	\$ 3,381,237	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		93,782	39
40	Mortgage Payable		3,637,502	40
41	Bonds Payable	194,924	3,645,000	41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 194,924	\$ 7,376,284	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 196,818	\$ 10,757,521	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 195,995	\$ 7,214,423	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 392,813	\$ 17,971,944	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 208,257	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 208,257	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(12,262)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (12,262)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 195,995	24 *

\* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 350,118	1
2	Discounts and Allowances for all Levels	( )	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 350,118	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 350,118	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	56,709	31
32	Health Care	184,896	32
33	General Administration	67,366	33
B. Capital Expense			
34	Ownership	27,377	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	26,032	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 362,380	40
41	Income before Income Taxes (line 30 minus line 40)**	(12,262)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (12,262)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. See Page 26

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	543	611	12,277	20.09	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	381	437	7,103	16.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	598	670	8,439	12.60	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	202	233	5,044	21.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	389	448	6,784	15.14	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,423	1,616	24,548	15.19	28
29	Resident Services Coordinator	466	531	7,653	14.41	29
30	Habilitation Aides (DD Homes)	10,797	11,838	124,419	10.51	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	14,799	16,384	\$ 196,267 *	\$ 11.98	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	13	\$ 375	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental	23	1,168	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	36	\$ 1,543		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
Bill Grahn	Administrator	0	\$ 5,044	Workers' Compensation Insurance	\$	3,250	IDPH License Fee	\$ 400
				Unemployment Compensation Insurance		992	Advertising: Employee Recruitment	
				FICA Taxes		14,343	Health Care Worker Background Check	
				Employee Health Insurance		16,587	(Indicate # of checks performed )	
				Employee Meals			Fee	25
				Illinois Municipal Retirement Fund (IMRF)*				
				Pension		3,686		
				Employee Physical Exams		166		
				Other Employee Benefits		678		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							Less: Public Relations Expense	( )
							Non-allowable advertising	( )
							Yellow page advertising	( )
B. Administrative - Other								
Description			Amount				TOTAL (agree to Sch. V, line 20, col. 8)	
Administrator			\$ 1,284				\$ 425	
Assistant Administrator			1,864					
Accountant			2,325					
Secretary			831					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Lindgren, Callihan & VanOsdol	Audit		\$ 570			\$	Out-of-State Travel	\$
Various	Computer Programmer		78					
							In-State Travel	
							Seminar Expense	263
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL		\$	TOTAL	\$ 263
			\$ 648					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Milestone-Sun Valley

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. \_\_\_\_\_
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 26,032  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. \_\_\_\_\_
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Lindgren, Callihan, VanOsdol & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

MILESTONE, INC.-Sun Valley # 0035386  
SCHEDULE VII-A: BOARD MEMBER LISTING  
FISCAL YEAR 2003  
07/01/02 THRU 06/30/03

<u>NAME</u>	<u>TITLE</u>	<u>TYPE OF SERVICE PROVIDED TO FACILITY</u>	<u>OWNERSHIP INTEREST IN</u>
Patrick Agnew	Director	Legal	Agnew Law Office
Ronald Alden	Director	Pension Accounting	McGladrey & Pullen
George Bass	Director	Insurance	Country Companies
Lyla DeVerdi	Director	N/A	
Alan Furman	Treasurer	N/A	
James Hamilton	President & C.E.O.	Administrative Services	
Peggy Hanson	Director	N/A	
Jack Kieckhefer	Director	Insurance	Kieckhefer & Nelson
Rick Powell	Director	N/A	
David Raht	Chairperson	Insurance	Williams Manny
Tom Sandquist	Secretary	Legal	Williams & McCarthy
Shawn Way	Vice Chairperson	Banking	Amcore Bank Rockford
Audrey Wickstrand	Director	N/A	

MILESTONE, INC. - Sun Valley #0035386  
SCHEDULE VII-A: RELATED PARTIES  
FISCAL YEAR 2003  
07/01/02 THRU 06/30/03

<u>MILESTONE, INC.</u>	RESIDENTIAL <u>BEDS</u>	<u>CITY</u>	TYPE OF <u>BUSINESS</u>
Central Office	N/A	Rockford	Central Office
Elmwood Heights	84	Rockford	ICF/MR-SLC
Elmwood East	12	Rockford	ICF/DD<16 & Fewer
Searles	12	Rockford	ICF/DD<16 & Fewer
Sun Valley	8	Rockford	ICF/DD<16 & Fewer
Javelin I	8	Rockford	C.R.A. - Waiver
Applewood	8	Loves Park	C.R.A. - Waiver/C.I.L.A. Services
Belvidere*	8	Belvidere	C.R.A. - Waiver/C.I.L.A. Services
Orchard	8	Rockford	C.R.A. - Waiver
Training Center	N/A	Rockford	Developmental Training
Industries	N/A	Loves Park	Developmental Training
RocVale Childrens Home	50	Rockford	Child Care Institute/DCFS
S.L.A.	N/A	Rockford	Client & Family Support
Dierks	8	Rockford	C.I.L.A. Services
C.I.L.A.	N/A	Rockford	C.I.L.A. Services
Windcloud	5	Rockford	C.I.L.A. Services
Prospect	5	Rockford	C.I.L.A. Services
Hanford	5	Rockford	C.I.L.A. Services
Rural	5	Rockford	C.I.L.A. Services
Flintridge	5	Rockford	C.I.L.A. Services
Old Golf	4	Loves Park	C.I.L.A. Services
Creekside	4	Rockford	C.I.L.A. Services
Javelin II	4	Rockford	C.I.L.A. Services
Windpoint	5	Rockford	C.I.L.A. Services
Riverside	5	Rockford	C.I.L.A. Services
Weymouth	5	Rockford	C.I.L.A. Services
Fleetwood	5	Rockford	C.I.L.A. Services
Stornway	5	Rockford	C.I.L.A. Services
Shiloh	4	Rockford	C.I.L.A. Services
Black Oak	5	Rockford	C.I.L.A. Services
Donna Drive	8	Rockford	C.I.L.A. Services
Respite Services	N/A	Rockford	Respite Services
Sawgrass	6	Rockford	C.I.L.A. Services
Crested Butte	6	Rockford	C.I.L.A. Services
Dental Program	N/A	Rockford	Dental Services
Thyme	6	Rockford	C.I.L.A. Services
Tulip	5	Rockford	C.I.L.A. Services
Packard	5	Rockford	C.I.L.A. Services
Country Club	5	Rockford	C.I.L.A. Services
HUD Project #071-EH003	N/A	Rockford	Housing
HUD Project #071-EH059	N/A	Rockford	Housing
HUD Project #071-EH178	N/A	Rockford	Housing
Bingo & Pull Tabs	N/A	Rockford	Bingo & Pull Tabs

\* Closed 05/07/03

**Milestone, Inc. - SUN VALLEY # 0035386**  
**Schedule of Federal Form 990 Reconciliation**  
**FISCAL YEAR 2003**

Page 19, Line 41	(\$12,262)
Related Organizations Net Income	\$1,198,011
Federal Form 990 Net Income	<u>\$1,185,749</u>

RECLASSIFICATION - SCHEDULE V. COLUMN 5  
Milestone, Inc. - SUN VALLEY # 0035386  
FISCAL YEAR 2003

SCHEDULE V		
Line #	Title	Amount
17	Administrative	(3,156.00)
21	Clerical	<u>3,156.00</u>
		<u>0</u> -----

To reclassify accountant & secretary from administrative personnel purchased at cost from Milestone Foundation, Inc.

30	Depreciation	425.00
35	Equipment Rent	<u>(425.00)</u>
		<u>0</u> -----

To reclassify rental of Computer from Milestone, Inc. Central Office.

30	Depreciation	186.00
36	Rent-Maintenance Building	<u>(186.00)</u>
		<u>0</u> -----

To reclassify rental of Maintenance Building from Milestone, Inc. Central Office.

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# **ADDENDUM**

## **A**

# **ADDENDUM**

## **B**